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ORIGINAL ARTICLES

MEDICINAL PLANTS.

WITH SPECIAL REFERENCE TO OUR EARLY MATERIA MEDICA.*

By H. P. LOVEWELL, M.D.
PROVIDENCE, R. I.

We have found our State a very satisfactory hunting-ground for the botanical collector. It has a varied topography and abounds in bogs, swamps and marshes, running streams and quiet ponds. It possesses a flora that is unique in many respects.

In the region of South Kingstown we have an intrusion of a Southern or pine-barren flora. At Wallum Lake, in the northern part of the state, is found a flora that suggests the region of the White Mountains and Wachusett.

Some three years ago we began to collect plants of medical interest growing wild in this State. There are at least three hundred plants growing within our borders that have in the past been credited with some medicinal value, although the true worth of a large number of these is doubtful.

The medicinal uses of many of our native plants have descended from the aborigines. The Red Men of the forests had a keen instinct for scenting out the medicinal and the poisonous plants; they had a *Materia Medica* of their own. They made use of certain plants as astringents and tonics; different species of the *Iris* and the root of *Mandrake* or *May-apple* were in common use as purgatives. At least a dozen plants were used as emetics, such as *Gillenia trifoliata* (Indian physic) and *Euphorbia ipecacuanha*. *Seneca* snake-root and *Virginia* snake-root were used as sudorifics. Their Anthelmintics were *Spigelia Marilandica* or *Carolina* Pink-root, the *Lobelia cardinalis* or *Cardinal-Flower*, etc. In "Father Smith's Indian Dispensary," we find mentioned *Wild Ipecac*, *Culvers-Root*, *Butternut*, "Nine-Barkroot," *Agri-mony*, *Horse-balm*, *Bark of White Pine*, etc., etc.

Johann David Schöpf in 1783 began the first scientific study of medicinal plants indigenous to

the United States. In pursuit of his studies he relates having visited Rhode Island and Connecticut. Unquestionably he received his knowledge of many of the plants listed in his "*Materia Medica Americana*" directly or indirectly from the native Indian.

The space allotted for this article allows us to mention but a few of the medicinal plants collected in Rhode Island:—

Araceae.

Orontium aquaticum,—the Golden Club. The root is acrid and poisonous, but becomes edible by roasting. Both the seeds and roots were eaten by the Indians.

Liliaceae.

Alettris farinosa,—Star grass. One hundred years ago Jacob Bigelow said, "I know of no plant which surpasses this one in genuine, intense and permanent bitterness. Neither aloes, gentian or quassia exceed it in the impression produced on the tongue." This bitterness has brought it into notice in the quality of a tonic and stomachic. Dr. Cutler, in his account of the plants of New England, informed us that this plant had been considered useful in chronic rheumatism. Millspaugh says *Alettris* was held in high repute by the aborigines as a stomachic, bitter tonic and emmenagogue. Parts used, rhizome and roots.

Erythronium Americanum,—Adder's tongue, Dog's-tooth Violet. The root was formerly used as an emetic, but its irritant properties are lost in drying so that it becomes bland. In two localities we have discovered quite large beds of this plant, although in some of its former haunts, it is getting quite rare.

Veratrum viride,—American Hellebore. A stout herbaceous perennial, two to four feet high. Leaves strongly plaited, the lower large, the upper very much reduced. Flowers in dense spike-like racemes, appearing in June and July. Found abundant in swamps and low grounds, associated with skunk-cabbage. Parts used,—the rhizome and rootlets. Official U. S. Pharmacopoeia; classed as a cardiac depressant; it is probably less likely to cause cardiac depression than is aconite, but is less efficient in the doses generally used. *Veratrum*

*This article was offered in explanation and collaboration of exhibition of certain botanical specimens of medicinal properties, at the quarterly meeting of the R. I. Medical Society, March 2d, 1922.—(Ed.)

viride has been suggested for chronic hypertension, and has been highly recommended for puerperal eclampsia. Instances of accidental poisoning are reported for man and for various animals and birds. The seeds have been specially mentioned as poisonous to chickens. The root has been eaten with fatal results by human individuals. Death is caused by paralysis of the heart.

Haemodoraceae.

Lachnanthes tinctoria.—Red-root, is found in sandy swamps near the coast. The rootlets are a deep orange red, stem erect, hairy above the last leaf, leaves are sword-shaped, mostly clustered about the stem. The flowers are a compound cyme, dingy yellow perianth woolly externally. The root was used by the aborigines (especially the Seminoles), as an invigorating tonic. It was supposed to cause a fearless expression of the eye and countenance, a boldness and fluency of speech. Overdoses said to resemble mild poisoning by *Belladonna*. Aside from its narcotic use by the Indians, it has been used for dyeing purposes. The drug is used by the Eclectics and Homeopathic practitioners for nervous disorders. Red-root was quoted by Darwin as influencing the color of the swine in the South. Black pigs eat it with impunity and survive; white pigs die; hence the prevalence of dark swine in that vicinity.

Phytolaccaceae.

Phytolacca decandra, — Poke - weed, Pigeon Berry. The medicinal uses of poke-root were handed down to domestic and botanic practice by the aborigines, who valued the plant not only as an emetic, but also as an efficient remedy in gonorrheal and syphilitic rheumatism. Among the earliest American writers this was considered fully equal to *Ipecacuanha* as an emetic. Its emetic action usually followed 10 grains of the powdered root. A tincture of the berries was valued in specific and non-specific forms of rheumatism. Millspaugh states that the berries have been used for pies by frugal housewives. The young shoots made an excellent substitute for asparagus. Berries and root official in U. S. P.

Ranunculaceae.

Cimicifuga racemosa.—Black cohosh, Black snake-root, Squaw-root, Bugbane. Description—This tall, graceful and showy perennial grows to a height of from three to eight feet; leaves alternate, tri-ternately divided. Inflorescence of a very

long or compound, wand-like upper axillary or terminal raceme. Flowers, scattered, foetid, creamy white. It grows in rich open woods and along the edge of fields. When woods in its favorite localities are at all dense, the plant will be found only in its borders. Black cohosh was a favorite remedy among all tribes of the aborigines, being largely used by them in rheumatism, disorders of menstruation and slow parturition. Also used by them as a remedy against the bites of venomous snakes. Extract and tincture official in U. S. P.

Berberidaceae.

Podophyllum peltatum. When your walks lead in the direction of deserted farmhouses, if you explore the region of the old apple orchard, you may find a plant not native of the State, but set out years ago for its medical value; we allude to the Mandrake or *Podophyllum*. It has very large leaves, and a single white flower about two inches in diameter upon a short, curved peduncle, blossoms in May and ripens its fruit in August and September. Parts used, the rhizome and rootlets. Over one hundred years ago the Shakers of Lebanon, N. Y., extracted an active principle which was very much sought by physicians. Mandrake was used by the Eclectics as a substitute for mercury in the treatment of syphilis and has even been dominated "Vegetable calomel."

Papaveraceae.

Sanguinaria Canadensis.—Blood-root. Most elaborate treatises have been written upon this most valuable plant by all writers upon botany and medical botany. The most extensive article ever published on this subject was written by Dr. Tully of New Haven, and published in the *Philadelphia Medical Recorder*. Williams says that it has always been a subject of wonder that the "Steamers" or "Thompsonians," had not selected this article for their almost divine adoration, rather than their more dangerous *Lobelia*. We consider it of value in those irritative conditions of the trachea that follow gripe conditions.

Leguminosae.

Cassia Marilandica.—American Senna. With its yellow petals and chocolate colored anthers is an interesting plant and possesses laxative qualities. It is apt to cause griping unless qualified by the seeds of anise, caraway, etc. The action of American Senna is similar to that of the African

drug, although it is much less efficient, a dose one-third or one-half larger being required to produce the same effect. The leaflets formerly official were dropped from the U. S. P. in 1882.

Geraniaceae.

Geranium maculatum.—Cranesbill. The American aborigines valued this plant as an astringent in looseness of the bowels and exhaustive discharges of all kinds. Schöepf recommended it as a remedy in the second stages of dysentery and cholera infantum. This has been justly considered one of our best indigenous astringents. The rhizome has a considerable percentage of both tannic and gallic gases. *Geranium* root is official in the U. S. P. in the form of the fluid extract.

Euphorbiaceae.

Euphorbia corollata.—Large Flowering Spurge. The flowers are in five to seven rayed umbels, the rays two to five forked; involucre white, petaloid, showy, on long peduncles; habitat in rich and sandy soil. This species is actively emeto-cathartic; in small doses diaphoretic (was once substituted for Ipecac in Dover's Powder). More pleasant to the taste than Ipecacuanha. This species undoubtedly used by the aborigines.

Aquifoliaceae.—The Holly's. In general, plants of this order are possessed of emetic properties. Holly has been more used in Europe than this country. Its bitterness led to its use in intermittent fever, but in this condition it has proven worthless. In large doses the leaves produce nausea and vomiting, while the berries cause both vomiting and purging. *Ilex opaca* is said to be somewhat demulcent and has been used in pulmonary affections to allay cough and promote expectoration. Professor Barton stated that the bark had long been popular as a remedy in different parts of the United States (Black Alder), being used as a substitute for Peruvian Bark. Most commonly employed in a decoction.

Thymelaeaceae.

Dirca palustris.—Leatherwood. Belongs to the Mezereum family. This is a marshy shrub, frequenting low woods in the vicinity of water. It is remarkable for the flexibility of its wood and toughness of its bark; a man cannot pull apart so much as covers a branch of half or a third of an inch in diameter. Benjamin C. Barton says that this was used as a blister and mentions the fact that some of our Indians used as a cathartic a

decoction of the bark of the root, and they also used it for their cordage. The fruit is a small, red, one-seeded berry and is poisonous. In effect similar to over doses of *Stramonium*. Jacob Bigelow stated that the properties of the *Dirca* were somewhat similar to those of *Polygala senega* (Seneca Snake-root), for which it might be substituted in small quantities. The flowers appear in April or May and fall before the leaves expand.

Araliaceae.

Aralia racemosa.—Wild Spikenard. Rafinesque states this plant was used by the Indians as a carminative, pectoral and antiseptic, in coughs, pains in the breast and mortification; the root, with horseradish, was made into a poultice for the feet in general dropsy. Culpepper's Herbal says that Spikenard is good to "provide urine and cureth the pains of the stone in the reins and kidneys." In domestic practice it has been made into a composite syrup with the root of *Inula helenium*, and used as a remedy in chronic coughs, asthma and rheumatism. Millsbaugh says drop doses of the tincture (of the root) promptly relieved a case of asthma in one-half hour and also exerted a beneficial effect in warding off recurring attacks.

The Umbelliferae.—Herbs with alternate, mostly compound, leaves and flowers in umbels; stems usually hollow. Leaves with dilated or clasping petioles. Umbels generally compound, the secondary ones being termed umbellets. A very important group comprising many species of medicinal or economic importance. An umbellate plant that grows in wet places should be regarded with suspicion until its character has been determined. The organ that shows the greatest amount of variation in form is the fruit and this should be carefully studied in the particular species.

Conium maculatum.—Poison Hemlock. Native to Europe and Asia but has become naturalized here. Parts used—the fruit gathered while yet green. U. S. P. Of the substances extracted from the plant, the chief is coniine. This is a colorless oily liquid with an unpleasant mouse-like odor and a biting taste. The juice prepared from the Hemlock has been used as a sedative and narcotic in various spasmodic diseases. Collection; the herb and unripe fruits are collected in June from second-year plants. Hemlock is a biennial.

Sanicula marilandica.—Sanicle, Black Snake-root. A perennial, two to three feet high. Leaves

five to seven times parted, the radical ones long-petioled. The styles much exceed the bristles of the fruit, recurved. Habitat—Woods and copses, Canada to Carolina and westward; common. Various contradictory properties have been assigned to this plant; as for instance that it is nervine, anodyne, and astringent. Its virtues are problematical.

Cicuta maculata.—Water hemlock. Of medical interest because it is one of the most poisonous plants indigenous to this State. Stem four to eight feet high, striated with green and purple. Leaves pinnately compound and serrate leaflets, involucre usually none, involucels of several slender bracelets and white flowers. Habitat—in swamps and wet places; common everywhere. This plant has fasciated roots and is especially dangerous because these roots have been frequently mistaken for horse-radish, parsnips, artichokes or sweet cicely. Symptoms—vomiting, colicky pains, unconsciousness, convulsions, ending in death. Porcher says, "The leaves, flowers and seeds are narcotic, sedative, and anodyne. It resembles *Conium* in its effect and has been used as a substitute for it."

Cornaceae.—In our tramps in early spring the Cornels or Flowering Dogwoods are of much interest, and the more so when we learn they possess an active principle cornine, an alkaloid having properties similar to quinine and much used by the Southerners during the Civil War as a remedy in malaria. The only flowering shrubs with which the Dogwoods could be confused are the *Viburnums*, but their flower is a star with five rounded divisions and five stamens. If it is remembered that the Dogwoods are always in fours and the *Viburnums* in fives the difficulty is removed.

Ericaceae.

Chimaphila umbellata.—Pipsissewa. The aborigines used this as a tonic and diuretic as well as for rheumatism and scrofulous disorders. Closely resembles *Uva-ursi* in its action and used for like purposes; beneficial in chronic affections of the urinary organs. Fluid extract of the leaves is official.

Uva-ursi.—Bearberry, Upland Cranberry. Not much used until the middle of the eighteenth century. Admitted to the London Pharmacopoeia in

1763. It is astringent, tonic and diuretic. The leaves are official in the U. S. P.

Gentianaceae.

Sabatia.—American Centaury. Jacob Bigelow in 1817 stated that he had no hesitation in attesting to the utility of this plant. It seemed to him to rank among the more pure or simple bitters.

As regards the Gentian family, both the Fringed and the Closed varieties possess bitter principles, but in a less degree than the official variety (*Gentian lutea*), which is imported from Southern Europe. Several varieties of *Sabbatia* were formerly used in intermittent fever, sometimes with curative effect. Another member of this family is the Buckbean, a rather attractive plant when in blossom and possessing the bitter tonic properties common to this order, also used as a laxative, the rhizome and leaves contain the active principle. As early as 1613 we find mention of a decoction of this drug being used to remove visceral obstructions, also as an emmenagogue, diuretic, and as a destroyer of intestinal worms. Bigelow considered that the root of this plant was entitled to a high place among our bitter tonics.

Apocynaceae.

Apocynum cannabinum.—Dogbane. The use of this plant has been traced directly from the aborigines to the present time. Professor Austin Flint in his lectures 1865-6 spoke of the use of this remedy in ascites and alludes to it in his "Practice" edition of 1866. It was in common use among the Sioux Indians of Dakota and Montana and the Cheyennes in Indian Territory. It was one of their favorite remedies as a cure for the bite of the rattle snake. The root was used freshly grated or dried. The dose of the powdered root given internally was two pinches for a child and three pinches for an adult.

Labiatae.

Lycopus virginicus.—Bugle weed. In incipient phthisis and hemorrhage from the lungs, this plant was a favorite remedy of Dr. Solomon Drowne, who was professor of Materia Medica and Botany in Brown University from 1811 to 1834. Drowne was deservedly celebrated for his scientific knowledge of the medicinal plants of this country. Millspaugh checked a serious case of epistaxis by giving teaspoonful doses of the tincture of the whole plant and laments that this valu-

able remedy was dismissed from the U. S. P. in 1882.

Solanaceae.

Datura Stramonium.—Thorn-apple. Seems to have been first introduced freely into practice by Baron Stork of Vienna as a remedy in mania, epilepsy, convulsions, etc. Commonly used in asthma. This practice was first suggested by the employment of another species, *Datura ferox*, for similar complaints in the East Indies. The external use of *Stramonium* is of much older date than its internal exhibition. Bigelow says, "In painful hemorrhoidal tumors the ointment of *stramonium* with the ointment of acetate of lead gives in many cases very prompt and satisfactory relief, being inferior to no other application with which he was acquainted."

Solanum Dulcamera.—Bittersweet. Flowers drooping, corolla wheel-shaped and five cleft, with two green ovate spots at its base, fruit a two-celled bright scarlet translucent berry. Bigelow refers to the splendid works of Williams and Bateman on "Diseases of the Skin," as giving some important testimony on the efficiency of *Dulcamera* in cutaneous affections.

Scrophulariaceae.

Chelone glabra.—Balmony, Turtle Head. Mills-paugh states that Balmony was for years a favorite tonic and laxative among the aborigines of North America.

Caprifoliaceae.

Triosteum perfoliatum.—Dr. Tinker's Weed, Wild Coffee, Fever root, Wild Ipecac. This plant is not common in any one locality, and generally occurs in limestone soils. Its medical properties are those of an emetic and cathartic. Schöepf speaks of it as an emetic only and alludes to its use in intermittent fevers and pleurisy. Some of the Germans of Lancaster County, Pa., used the dried and roasted berries as coffee, and found them an excellent substitute.

Compositae.

Tussilago Farfara.—Coltsfoot. This plant is very common in Europe and has become naturalized in some parts of this country, more especially in the Northern States. The generic name is from tussis and ago in allusion to its pectoral powers; and the specific one is from the resemblance of its leaves to a kind of poplar called by the ancients *Farfarus*. It was well known to the early writers

on *Materia Medica* and is spoken of by Hippocrates as a remedy in ulcerations of the lungs, and by Dioscorides, Pliny and Galen as an excellent remedy when smoked through a reed, to relieve obstinate coughs.

Inula helenium.—Elecampane. *Inula* was one of the most famous of ancient medicines and continued in vogue in the "Old School" until recent times. It owed the reputation it gained to its stimulant properties. In the writings of Hippocrates it was stated to be a stimulant to the brain, stomach, kidneys and uterus. This plant is now thoroughly naturalized in Europe and in our country. *Inula* is simply mentioned in the U. S. P.

We must not forget our native trees and shrubs, many of them having medicinal uses, the bark of the Oak is a valuable astringent. The inner bark of the Butternut is a mild cathartic resembling rhubarb. The American Aspen or Poplar at one time had a reputation of being a tonic and stimulant. From the Pine family are derived resins, which are much used as ingredients in plasters and cerates. The Hemlock bark is very astringent and is much used in tanning. It appears to have no special advantage over other common vegetable astringents. The American Yew we have not as yet discovered wild in this State, although it has been reported as located in certain sections. It is believed to have poisonous properties. Witch Hazel or *Hammamelis* is well known and contains astringent principles. The Buckthorn, although native in Eurasia, is found here both cultivated and escaped. It is a powerful laxative. The species found in Rhode Island has been used by veterinaries.

In pursuit of the medicinal plants of this State, it is first necessary to find if the species sought are native to this region. We have found Bennett's *Flora of Rhode Island* of decided help. The Providence Franklin Society have published a revised edition of this work. Provide yourself with topographical maps of the region you are to visit. A camera should add interest to these trips, but do not expect satisfactory pictures of plants taken when the wind is rated at sixty miles an hour.

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REMARKS ON THE CLINICAL INTERPRETATION OF THE WASSERMANN REACTION.*

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The Wassermann reaction has been much abused both by its friends and severe critics. This abuse is the result of expecting too much of the test or from not interpreting the results obtained in the proper manner. I shall try to run over in a few words some of the pitfalls in the road of the proper interpretation of the Wassermann test.

The Wassermann test is not a specific reaction for syphilis and there are a few conditions aside from syphilis which will produce a positive reaction. There is a lack of unity in the opinions of the various observers as to what conditions aside from syphilis will give a positive Wassermann reaction. Leprosy, malaria, trypanosomiasis, acute infections such as scarlet fever, pneumonia and tuberculosis have been stated to give a positive Wassermann reaction at times. For practical purposes, however, it may be stated that in this climate there is very little reason to make errors because of other diseases than syphilis which give a positive Wassermann reaction. As a matter of fact, investigation in this community shows that tuberculosis is not a complicating factor in the production of a positive reaction, nor is there any evidence at hand to show that malaria will give a positive reaction. Trypanosomiasis and leprosy need not be considered. It is only necessary then, to avoid taking a test in the presence of

acute infections. We may, therefore, consider that the Wassermann reaction, if properly performed, is good evidence of syphilis if it is strongly positive.

The question of proper technic is of course a very important one. There are so many modifications of the original Wassermann technic varying in the degree of sensitivity, that certain allowances have to be made for this in the interpretation of any given result. The more sensitive the antigen used, the higher number of positive results will be obtained in any given group of sera. Thus, a case may give a negative reaction as reported by one laboratory and a positive reaction as reported by another laboratory, depending on the greater or lesser sensitivity of the antigen used rather than because of any technical error. It may be taken for granted, however, that any good standard technic which gives a positive reaction with the patient's serum may be considered as suggestive of syphilis. It must be borne in mind at all times that the Wassermann technic is a very delicate one and depends upon several biological reagents which vary in sensitivity from day to day and under differing circumstances and further, that the quantities of the reagents used involves the result. It is easy to realize that errors occur in the technical procedure, and it is possible that the result reported by the laboratory may be an error. We may, therefore, speak of false negative and false positive reactions. In any good laboratory such errors will be very infrequent but they are always possible and it behooves the clinician to bear this fact in mind when interpreting the positive or negative reaction in terms of syphilis in a patient.

A study of the reports of two laboratories on the blood sera of 3,000 patients was recently made by me. This study showed that there was a complete uniformity in the findings of the two laboratories in 93.44 per cent. The 6.56 per cent. variation included cases reported as doubtful. Considering only the variation of cases reported positive by one laboratory and negative by the other, the percentage of variation was 4. This was 1.4 per cent. positive in one laboratory and 2.6 per cent. positive by the other laboratory. Some of the cases reported positive by one laboratory and negative by the other were known to be syphilitic so that the negative reaction was the

*Read before the Section in Medicine of the R. I. Medical Society, February 28, 1922.

incorrect one. Considering, then, the cases that either laboratory may have reported as positive in cases not known to be syphilitic and which were reported negative by the other laboratory, the percentage was 3.16. This is probably a higher percentage for false positives than actually occurred, as some of these cases were probably syphilitic. This percentage variation is based on only one test. Repetitions resulted in a uniformity of findings in the majority of cases. This study indicates that there are relatively few false positives reported by a good laboratory. It does indicate, however, that there is apt to be an occasional error if the results of one test are taken as conclusive. The possibility of technical error creeping in can be largely avoided by having a test repeated and the variation in result that is likely to occur according to the technic used can be partly overcome by having the test performed in more than one laboratory. While the variation in the reports of the two laboratories quoted are quite insignificant considered from the standpoint of statistics, they are of very great importance when considered from the standpoint of the individual patient. It is the clinician's duty to take steps to prevent the wrong diagnosis being made upon a patient because of any difficulty or error in the performance of the test. The final interpretation of the result lies, or should lie, entirely with the clinician. Where the clinical evidence of syphilis is sufficient to make the diagnosis, the Wassermann test is only of importance in corroborating clinical information. If it should be reported as negative in such a case the clinician should either say, "so much the worse for the test" or have it repeated. This should be true in those cases in which there is no evidence of syphilis from a clinical standpoint and the laboratory reports a positive reaction. In such cases the report of the laboratory should be confirmed by a second test or even a third.

One negative reaction should not be considered as excluding syphilis but the test should be repeated. The Wassermann laboratory of the Massachusetts Department of Health prints on its report blanks the following statement: "negative does not exclude syphilis. In dealing with obscure conditions less than three negatives has little diagnostic significance."

There can be no doubt whatever that a negative

Wassermann reaction may be obtained in the presence of syphilis in the patient even if repeated many times. More will be said on this matter in a minute. The presence of a consistently positive Wassermann reaction may be considered as *prima facie* evidence of syphilis in this locality provided only that the laboratory which made the report is reliable and that the patient is not suffering from an acute febrile disease. It must always be borne in mind, however, that while the patient may have syphilis, the symptoms from which he suffers may not be due to syphilis. In other words, a chronic disease as prevalent as syphilis may be present coincidentally with other pathological conditions.

The Wassermann reaction is important not only as an aid in diagnosis but also in following the progress of the case during treatment. One desires to see a patient become Wassermann negative. This, however, should not be the whole consideration in the treatment of the syphilitic. In the first place, we have as yet no definite proof that the negative Wassermann reaction means a cure of the disease; in the second place, as Wile has pointed out, a negative reaction as obtained with one Wassermann technic would be reported as positive if performed by another technic; thirdly, there are a great number of late cases of syphilis that will apparently never become Wassermann free, yet the patients will be in good health and apparently immune from further evidence of the disease; and in the fourth place, a reaction which becomes negative under treatment may shortly become positive again after the cessation of treatment.

A word may be said as to the value of the test during the period of treatment. It is often stated that the test has no significance if the patient has recently had arsphenamine or mercury. As a matter of fact, a study of a great many cases under treatment has shown that in only a small minority do a few injections of mercury or arsphenamine, or the two combined, have any effect upon the Wassermann test. It does occasionally happen that a strongly positive Wassermann reaction may become negative after one or two injections of arsphenamine. This, however, is an exceedingly rare phenomenon and in a general way, it may be stated that if a patient has had only a few injections of arsphenamine or mercury, the test will be fairly reliable. If a patient has had a consider-

able amount of treatment, however, and if he is apparently approaching a serological cure, that is, reaching a period in which the Wassermann reaction will be consistently negative, there is a period in which there will be a great variation from week to week and the result of the test in such cases will be found to be negative one week and the next week will again be positive. This merely indicates that one negative test during treatment cannot be taken as evidence that the patient will remain Wassermann negative for any period of days.

As already mentioned, a negative Wassermann reaction is not evidence of the absence of syphilis in the patient even though this negative Wassermann reaction be confirmed by many tests. This has been brought out from a pathological standpoint by Warthin. From a clinical standpoint, this can be seen probably to the best advantage in syphilis of the nervous system. In general paresis, the Wassermann reaction is positive in the blood from 95 to 98 per cent. of the cases. In tabes and cerebrospinal syphilis, however, the Wassermann reaction in the blood is positive in probably only 60 per cent. of the cases. In other words, 40 per cent. of the cases of tabes and cerebrospinal syphilis in which there is absolute evidence of an active syphilitic process from a clinical standpoint and from an examination of the spinal fluid, will give negative Wassermann reactions in the blood. It follows that a negative blood Wassermann reaction is of comparatively little significance for the clinical diagnosis of tabes or cerebrospinal syphilis. If this is borne in mind no criticism is attached to the Wassermann reaction in these cases. It is necessary whenever these conditions are suspected to perform a lumbar puncture and examine the cerebrospinal fluid. This is equally true in using the Wassermann reaction to check up the progress and the treatment of the case. It must at all times be borne in mind that the blood Wassermann reaction is not an indication of a condition of the central nervous system. It will be found that cases under treatment which had a positive blood and spinal fluid Wassermann reaction at the beginning of the treatment will show a non-concomitance of the tests in the blood and cerebrospinal fluid. There are some cases in which the blood Wassermann reaction will become negative in a comparatively short period,

whereas the cerebrospinal fluid Wassermann reaction will remain positive. This occurs in general paresis, cerebrospinal syphilis and tabes dorsalis. On the other hand, there are many cases of syphilitic involvement of the nervous system in which after treatment the cerebrospinal fluid Wassermann reaction will become negative, whereas the Wassermann reaction in the blood will remain positive.

The Wassermann reaction in the cerebrospinal fluid may be negative in cases of syphilis of the nervous system. This is exceedingly rare in general paresis where it happens in less than 1 per cent. of the cases. It is a little more frequent in cerebrospinal syphilis and tabes dorsalis and rather frequent in vascular neurosyphilis. The diagnoses must be made on the history, clinical symptoms, and other cerebrospinal fluid tests.

A word may be said as to the so-called provocative Wassermann reaction. Swift was the first to state that in some cases of syphilis giving a negative blood Wassermann reaction the administration of arsphenamine would lead to the production of a positive Wassermann reaction. This has never been very firmly established and it is probably true that the same result would be obtained by the repetition of the test on several occasions without the administration of arsphenamine. However, with a difference of opinions on this matter, I would not wish to be dogmatic in my statement.

SUMMARY.

A consistently positive Wassermann reaction in the absence of acute febrile conditions is evidence of syphilis in a patient in the United States.

A negative Wassermann reaction is of little clinical significance in ruling out syphilis.

One positive Wassermann reaction in itself should not be considered as conclusive evidence of syphilis, as technical errors may have occurred. It should always be checked by at least one other confirmatory test.

The technic used is of importance in the interpretation of the Wassermann reaction, as the more sensitive the antigen used the greater percentage of positive results will be obtained. It is to be remembered that syphilis may be concomitantly present with other conditions and that the present-

(Continued on Page 252)

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EDITORIALS

CHIROPRACTORS AND OUR DUTY.

It requires no argument to prove that chiropractors are doing a flourishing, and for them, a very profitable business. Likewise, it is abundantly clear that the public, both intelligent and unintelligent, are being fooled by chiropractic propaganda. Not a day passes but some poorer but wiser individual comes into our consulting rooms and informs us about "spinal adjustments" suffered at the hands of chiropractors. These "ad-

justments" have cost money and have been inflicted without even a pretense, nay more, with a brazen denial of the need of, an antecedent diagnosis. The result—empyema unrecognized; rheumatoid spines irreparably damaged; tuberculosis allowed to progress while chiropractic tinkering is in progress; syphilitic spinal cord lesions permitted to advance, and a hundred more equally serious conditions unchecked while these sordid charlatans are reaping a financial harvest from the sufferings and the blind faith of afflicted men and women and little children.

And what are we doing about it, we of the medical profession, to whom people look and rightly look for guidance? The day of merely individualistic medicine is gone forever, because our very achievements in science have compelled us to develop a social conscience which finds its satisfaction in the fulfillment of social duties. And yet what are we doing? Well, for one thing, we are letting the tyranny of past traditions seal our lips; we are practically dumb. With every loud-mouthed quack and cheat dinning his words into the public ear and scattering his printed lies with every mail delivery, we remain silent; or if we speak it is with ineffective voice, lacking both the force and the influence which come of organized effort. We say it is not dignified, it is not professional, it is not a lot of other things for doctors to address the public. Why in Heaven's name is it not? The world has moved since we were almost a priestly caste. Shall we alone of the professions stand still? When everyone is speaking, shall we permit the purveyors of falsehood to hold the stage while we who have ever striven and do now strive to serve the truth, remain silent?

We do less than our duty when we fail to educate the public mind in matters concerning health and disease. By whom will the man in the street be led if not by us? Why, by the charlatans who are leading him now. Sick men and women do not go to chiropractors for any other reason than to regain their lost health, and by chiropractors they have been told week in and week out that health is to be regained by "spinal adjustments." Only by personal experience do they learn the frequently cruel deception of the whole business and the crass commercialism that motivates it. Would it be too much to ask of the medical profession that it speak out on behalf of the truth? The chiropractor fattens upon the public ignorance, credulity, and desire for health, and he feeds the public before devouring it on—printer's ink. Can we really blame the ordinary uninstructed man who believes the uncontradicted chiropractic advertisements? To ask such a question is to answer it. There is decadence enough in public and private life without adding medical decadence to it—and that we certainly do in the measure that, without contradiction from us, we allow chiropractors and other social leeches to suck the lifeblood of the sick and the maimed. In New York

they have combined the efforts of the Medical Society of the State of New York and the Medical Society of the County of New York to oppose the proposed bill for the licensing of chiropractors. What are we in Rhode Island going to do, for certainly the same gentry will attempt to obtain legal recognition here? As medical doctrine chiropractic is less than contemptible, but as a public menace it should call forth our united and therefore effective opposition.

MEDICAL SPECIALTIES.

The practice of medicine is becoming diversified. No longer does the family physician attempt to treat all the diseases of which his patients are found victims. He often sends them to other physicians, who by training and experience are fitted to diagnose and treat special diseases or diseases of special organs. The family physician is honest and wishes only that his patients shall receive the best possible medical advice and treatment, even at personal financial loss. This is as it should be, for the practice of medicine should never come to the point when it is considered a purely commercial enterprise. Should that time ever come the public would no longer trust and revere physicians as they have and still do.

When a physician recommends one of his patients to a specialist he selects one whom he knows to be fully capable of treating his patient. He is in a position to know what training and experience the physician specialist has had, and is well informed as to his success in his chosen field. It so happens that the public is being educated to the advantage of consulting specially trained men. They know that hospitals utilize specialists in certain departments and are well informed that result of treatment is superior to that obtained by the general physician, who cannot to-day meet all the situations as he did in days gone by. It is becoming common for people to directly consult specialists for bodily ills. Before consulting one, they often make inquiries from friends, and acquaintances, and sometimes from hospitals, but for obvious reasons not very often from the family physician. It would seem that the time has come when physicians who specialize in certain diseases should be permitted to put on their sign some word or words which will indicate the nature of their specialties. Then the public would be able

to select intelligently properly qualified physicians. This subject is not new, of course, and has been talked about for several years. It is surely time, however, that some action should be taken.

In Rhode Island the State Board of Health licenses all physicians for general practice. This should, of course, be continued for all physicians, but this Board should be authorized to grant to qualified men a special certificate indicating what specialties they may practice, and at the same time be allowed to use some designated words or letters on their signs indicating these specialties. Such a privilege should be granted only after these men had been examined by recognized specialists in each line, giving due consideration to education and practical experience in a medical school or special hospitals. This would not prevent any physician from treating diseases belonging to specialists, but it would prevent him from advertising himself as a specialist until he has duly qualified. The public would then be protected. They would have a way of knowing who are qualified in the opinion of medical profession. If any person chose to go for treatment to any other physician for a condition which is generally treated by a specialist, that is his business and responsibility since he has a way of knowing who are the best qualified specialists.

Young men are flocking into specialties, some are properly trained, many are not. Likewise, older men are turning to them because the work is not so arduous or the remuneration is better. The result is that much poor work is being done in the name of surgery and will, if unchecked, lessen the repute in which doctors are now held. Some such method for the designation of qualified specialists is necessary in justice to the public and properly trained specialists, and works no hardships on physicians in general, for it does not prevent them from treating any disease they feel themselves qualified to treat.

Chiropractics, osteopaths and healers of many kinds are appearing and clamoring for recognition. But so long as our "own house" is in order, we never need fear that they will long flourish or seriously compete with scientifically educated physicians. There have always been quacks and always will be, but so long as the regularly educated physicians honestly and faithfully serve the public, legislative recognition will never be extended to them.

FUMIGATION.

Inasmuch as there is still, especially in the rural districts, considerable ignorance concerning the value of fumigation after contagious diseases, would it not be wise for the profession to disseminate wherever possible the present day teachings with regard to contagion? When one recalls that the use of a noxious gas in an apartment where contagious diseases have been housed, has been in vogue for generations, and that the easy, but futile plan of burning some potent material appeals to the public teachings of years, as well as to a certain innate desire to kill an unseen enemy, it is easy to see that in this instance the unlearning may be much more difficult than the first learning. A recent editorial in the *New York Times* suggests that in some communities it may be wise to continue fumigation for a time to satisfy the desire of the public while they are passing through the unlearning period.

Perhaps the easiest way to enlighten the people is to teach the present doctrine of "carriers." This appeals in a rational way to most people and they see very easily the uselessness of burning a stinking gas in a harmless room when the germs of the disease are outside, living a parasitic existence in the former patient. Probably the amount of money and time still spent annually in fumigation is considerable, and time will undoubtedly remedy the situation, but a great deal of educational work could be done by physicians as they go about. The greatest good, of course, will come not so much in explaining the lack of value in gas fumigation as in teaching the status of carriers, for unlike many teachings which have had to be unlearned, fumigation has done no greater harm than to lead to a false sense of security.

LETTER FROM OUR ASSOCIATE-AT-LARGE.

ODDITIES OF EGYPT.

Luxor, Egypt,

February 7, 1922.

The real tale of my adventures begins with our landing at Alexandria. The trip on the Adriatic, as one may judge from my first letter to the *JOURNAL*, was not an entire success, and the disembarkation at our first Egyptian port was a culmination of poor service on the White Star Line. Some six hundred of us were called for early breakfast, marched up one staircase and down

another for medical inspection—the doctor only looked at the young girls—then up again for visé to passport, which was perfunctorily done by a gorgeous official in a red fez, then down to the lower deck, where we were crowded for an hour and a half before we were allowed to go on the tender. There was a special train to take us to Cairo, scheduled to leave at 11 o'clock, and we reached shore just in time to scramble for seats. But we could not leave till our luggage came ashore and had been identified, passed through customs, weighed, registered and finally put on the train. An hour later the baggage tender came and dumped on the dock twelve hundred odd trunks and some two thousand pieces of hand luggage.

The charge of the six hundred at Balacava was nothing to the rush of the six hundred at Alexandria in an endeavor to locate their luggage. When found, it was necessary to lassoo a porter with a coin, get him to carry it to the gate, bribe the official to pass it without inspection, get another porter to carry it to the registration office. There were two men to guess at the weight of all the luggage, charge you what they thought you would stand, then a third porter to put it on the train. All of this required five hours of strenuous work and in my own case required me to dispense with something like three hundred piastres in tips and fees—about thirteen dollars—and then the 11 o'clock train started. There were not enough seats and a friend and I, to find a resting place for our wearied bodies, went to the dining car, and in order to remain there till we reached Cairo we had to buy a lunch, an afternoon tea, three beers a bottle of wine and an after-dinner coffee.

Long after dark we reached Cairo and encountered several thousand wild Arabs fighting for our luggage with cries that would wake a mummy and after a free fight, a knock down and a hundred-yard dash combined with an obstacle race, we reached the bus which was to take us to Shepheard's and here our troubles ended. Since then it has been one long dream of delight, a passing panorama of Oriental life. A wonderful picture of changing colors. Whatever I have said derogatory to Cook and his excursion robberies, I take it all back when speaking of his Nile trips. The boat, food, service and beauty of the trips are par excellence.

But I am ahead of my story. As I sit here writing while the rest of the party have gone on donkeys to see where Cleopatra entertained her friends some years ago, I can see the ship's library of some two hundred volumes, all on Egypt. If you want statistical, financial, historical or ethnological facts, I refer you to that library. What I write will be only what in a weak moment I promised your Editor I would do, and as a caption I would suggest, *Odd Things I Saw in Egypt*.

I am not strong on music but I believe there is a "ff" which means strong and forcible. I have already found a "ff" in Egypt and it stands for fleas and flies and the biblical plague of flies is better understood. Speaking of the Bible, there is in the Cairo Museum a papyrus called the Book of the Dead, and as we passed by, the guide explained to us how much of our knowledge of Egyptian lore was due to the facts discovered in its pages; and behind us were three ladies of uncertain age, but certainly English; one said to the others, "In that case is the Book of David, the Psalmist, and that is the original manuscript of the Psalms. When you get home you must tell Maria, she is so interested in the Bible."

Speaking of Maria reminds me of our first donkey ride into the desert to see the ruins of the old city of Memphis, of Sakara and the tomb of Ti. Some five thousands of years have elapsed since there was any life either in the city or tomb. We had four donkeys, named Black Diamond, Whiskey, Telephone and Maria. In spite of the name of the latter, his actions and bray gave rise to doubts regarding the sex of the beast and with his tendency to amble off the road to browse on the alfalfa and a desire to lay down and roll, Maria was not a success. When a six-foot man strides a donkey he either gets cramps in his legs or else ploughs a double furrow with his feet on each side of his mount. There is another feature of a twelve-mile donkey ride in its effects on a novice which modesty and a lack of knowledge of the Egyptian word for that part of anatomy forbids me to mention. In spite of these drawbacks, it was an enjoyable five miles into the desert, nothing but sand, not a vestige of green, passing on the way a camp of Bedouins, with their picturesque, gaily colored tents, their flocks of goats, donkeys and camels and a double measure of naked children. The tomb of Ti, discovered

only a few years ago, is one of the oldest of Egypt's old relics and the hieroglyphics and wonderful coloring in one of its chambers is a commentary upon the art and skill possessed by the Egyptians five thousand years ago and a contrast to the squalor and ignorance of the country to-day, were it not enlightened by a British protectorate.

Dendara, where we stay to-day to pay a call on Cleopatra, is a city of some three thousand people. There is, I think, about three houses which are not mere hovels of dried mud, some without roofs, all without furnishings of any kind, not a school, not a church; and not over one in a thousand can read or write Arabic. They all know one word, *Bakshish, they are all beggars, and aside from this word, which we hear on all sides, their language reminds me only of a man with quinsy, gargling his throat.

The Nile is Egypt, without it it would be an arid desert and they have certainly learned in the years of its history the science of irrigation. Since we left Cairo ten days ago, I have seen nothing modern until to-day. The banks of the Nile at this point rise in sharp cliffs about eighteen feet above the level of the water. The problem of getting water to the fertile fields beyond is the same as thousands of years ago and is solved in the same way as their ancestors. An excavation is made in the bank at the water's edge, forming a sort of well, then six feet above this another hole is made and a canal dug shorewards, then six feet higher a third. These wells are drained by pieces of burlap covered with mud and at each well are two palmwood posts connected by a horizontal piece of wood. On this as a fulcrum is a long well sweep, the counter weight being the roots of a young date, palms made heavy with dried mud. All this apparatus is kept in position by thongs made of palm fibre and at the end of the sweep is dependant a long stick with a stall bucket at its end. It is exactly as our own well sweep at home. These are in pairs and two men at the water's edge pull down the sweep, fill the buckets, and as they rise empty them into well

No. 1. There two men repeat the process to No. 2 and so on to the top, where the water is emptied into the irrigation ditches. These relays are from two to four, depending on the height of the bank. I have been interested in estimating the volume of water delivered by this method in the well just opposite the Sudan. There are eight men at work. The buckets hold about two gallons each, the pair four gallons, and it takes eight seconds to complete the process. Thus there is delivered by the combined labor of eight men thirty-two gallons of water a minute to the fields above. Allowing for an error of estimated quantity, it is safe to say that not over fifty gallons can be delivered.

Just above the landing place is a gasoline certified pump which supplies water to the city and delivers two thousand gallons a minute. This furnishes water for irrigation of fields not close to the water's edge and what the inhabitants use for drinking and cooking. They never bathe, if one may judge from their appearance.

After a somewhat violent altercation with the proprietor, I last night stepped into one of the houses to see what were the actual living conditions. A mud-walled house about twelve feet square, a roof of bamboo covering only a part, and within, in one corner a raised dais of mud about three feet square, a crooked stick stuck in the ground from which suspended an old five-gallon gasoline can and under it the remains of a fire. No windows, no floor covering, no seats, no table, absolutely all there was in this house, save two women and four children and a dog; the man of the house was outside and I don't see how he could well get in. Dirty, squalid, with their faces marked by pigment, and slashed by cuts, they gave me a decided repugnance to Dendara or Egypt as an abiding place.

They believe that by making certain cuts and stains on their faces, particularly on the temples, they can avoid disease and especially the ophthalmic, which is so prevalent in the country. . . . This interruption was when I went to my room to investigate a new kind of flea. This one was white, ordinarily they are black. As I was saying, ophthalmia is everywhere. Trachoma in its varying stages is so common that after a while one scarcely notices it, but walking the streets of Cajro or Asyut one meets scores of blind and sees hundreds of children with swollen, purulent lids, faces

*Pronounced Boksheesh—A cry for alms common to all languages through all Mohammedan country from the Dardanelles to the Straits of Malacca. One's very presence in the garb of respectability is in itself sufficient reason for tribute, the persistence exhibited in the collection of which would be worthy of a great cause.—(Ed.)

covered with flies and often no attempt made to dislodge them. The only wonder is that they are not all blind. I thought I saw the height of squalor in China, but in some portions of Egypt it is even worse. No wonder there is unrest in Egypt. I am restless myself, but that is probably due to the fleas. Wine is good and fairly cheap. The Danish beer is excellent and as one cannot drink Nile water, temperance pledges are broken daily and sometimes nightly as well.

We went one night to an Egyptian restaurant for dinner. We wanted then to get the true Egyptian flavor, we want now to restrict our eating to the excellent fare we get on the boat. This was the menu of a table d'hôte dinner: Soup made of the feet of young kids, and tripe very greasy, but eatable. Bread baked in large round masses. No butter, but you dipped pieces of bread in a dish of olive oil, beets and garlic. Calves brains rolled into little balls and fried in oil. Chopped goat cooked the same way. Salad of lettuce, all of doubtful cleanliness. Coffee, thick and sweet, eaten with a fork. Very good oranges, and all this for six people for one hundred and sixty piastres.

It was a goat dinner, not good dinner, and afterwards we all said ba-ba, never again. It costs fifty piastres to take a bath and there are several ways of doing it. You either strain the water or else allow the mud to dry on your body and then the boy comes with a stiff brush and cleans it off for you. It is the same price either way, although in the latter you have to tip the boy.

Of course, in Cairo we went to the Pyramids of Chiza, rode on camels and had tea at the Mena House, everybody does the same, but at my age the moonlight trips to the desert did not appeal to me and the scarabs and antiquities offered for sale had the flavor of Attleboro, so I bought none. At Asyut we met the shawl sellers and they did a thriving business with the ladies. They are very pretty but weigh a ton, more or less, and I shall probably have to pay excess baggage for the rest of my trip, but there is nowhere for sale any object characteristic of the country which appeals to me. Of the visit to Kanak Thebes, its temples and tombs, I have no time to write. You can get all information from Badeker on the library. Of more interest to me are the boats.

*Photographs only can adequately describe them, but the feluccas, with their peculiar lateen sails,

their curious up-turned bows, wide gunwales on which they stand to pole the boat upstream, slowly drifting on the placid waters of the Nile, the green of the fertile planes, the yellowish brown of the surrounding mountains and above all the wonderful blue of the sky, at sunset changing to the hues of the rainbow, form a picture of the Nile never to be forgotten.

Had I the gift of words, I could not make a word picture adequate; were I an artist, I could not do it justice in a painting; a poet, I could not sing its praises in verse, but in memory it stands unrivaled. Never to be forgotten. The wondrous, the glorious Nile.

F. T. R.

LETTERS TO THE EDITOR.

To the Editor of the RHODE ISLAND MEDICAL JOURNAL:

While it is certainly true that there are some new things under the sun, it is rather surprising to discover how long ago one or another of our medical procedures was known to a few, at least, of our forebears. I am sending you the brief account which follows with the hope that it may prove to be, perhaps, of some interest to my ophthalmic colleagues if indeed they have not already come across it themselves. I am taking it from Dr. E. T. Withington's excellent Medical History from the Earliest Times.

William Fabry, of Hilden, near Dusseldorf, whose name is recorded in medical history as Fabricius Hildanus, was worthy to have been the Pare, or even the John Hunter of Germany; but he was unfortunate in the time of his birth, for the good seed he sowed fell on fields already planted with the tares of Paracelsic mysticism, and destined to be ploughed by the cannon of the thirty years' war. Though without a university education, he had gained an intimate knowledge both of Latin and Greek, and it was the object of his life to raise surgery to the dignity of a science, and the surgeon to the rank of the physician. His chief work was entitled "Six Hundred Surgical Cures and Observations," from which I am abstracting the following: On 25 April, 1624, he writes to a Dr. Hagenbach, regretting that an attack of gout prevented him from going to the latter's wedding, and in the spirit of the occasion he relates the following case as an example of the

advantages of being married: "A countryman, Benedict Barquin, bought some iron and was striking two pieces together to prove its quality, when a splinter flew into his eye and stuck in the cornea, causing him great pain. The local surgeons tried everything for many days to no purpose, and the pain and inflammation so increased that he came to me at Bern on 5th March. I used all means I could think of for some days, but the splinter was so small that it could not be removed by instruments. When behold! my wife hit upon the very thing. I kept the eye open with both hands, while she held a magnet as close as possible to it, and after several trials (for he could not stand the necessary light long) we saw the iron leap from the eye to the stone."

This ingenious lady was a French Swiss from Geneva, named Marie Calinet, who, in her husband's absence, could treat not only diseases of her own sex, but even cases of fractured ribs and legs, and as the above instance shows, she would make an excellent person to have about the office of an oculist.

JOHN DONLEY.

Baltimore, March 27, 1922.

To the Editor of R. I. MEDICAL JOURNAL,

Dear Sir: The book on "The Physician Himself," of which I am the author, has been out of print for nearly three years.

In view of the widespread good it has done our guild as a unit, and its usefulness to the individuals who possess it, The F. A. Davis Co., for a small money consideration, returned its copyright to me more than a year ago.

Glad of the chance to use my pen on it again, I have given it a searching farewell revision, eliminating much that was obsolete, and adding a great deal that is useful in an attempt to make it as pure, refined and clear cut as the classics. I have named this "The Crowning Edition." It was issued from "The Lord Baltimore Press" yesterday and a copy for you is already in the parcel post. I hope you will scan it closely.

I trust its unique theme and useful mission may mingle with your other thoughts. * * * The expense of producing the book has been far greater than expected, but if its sales bring me out even, I shall be satisfied.

Very sincerely yours, etc.,

D. W. CATHELL, M.D.

Emerson Hotel, Baltimore, Md.

SOCIETY MEETINGS

RHODE ISLAND MEDICAL SOCIETY.

A meeting of the "Section in Medicine" of the R. I. Medical Society was held at the Medical Library, Francis Street, Tuesday, March 28, 1922, at 8:45 P. M.

Paper: "Faulty Postures," Dr. Lloyd T. Brown of the Harvard Medical School.

Collation followed.

CREIGHTON W. SKELTON, M.D., *Sec.-Treas.*

PROVIDENCE MEDICAL ASSOCIATION.

Monthly meeting was held Monday, March 6, 1922, at Rhode Island Medical Society Library, Francis Street, at 8:30 P. M.

Program: Paper—"X-ray Treatment of Tonsil Infections," by Dr. Isaac Gerber.

Paper—"Significance of Bladder Symptoms in Women," by Dr. Eric Stone with the collaboration of Dr. James A. McCann. Case studies of patients seen in the O. P. D. Rhode Island Hospital.

Discussion opened by Dr. J. Edwards Kerney. The Standing Committee has approved the application of Louis I. Kramer, M.D., 304 Smith Street. Collation followed.

PETER PINEO CHASE, M.D., *Secretary.*

WOONSOCKET DISTRICT SOCIETY.

Regular monthly meeting of the Woonsocket District Medical Society was held at St. James Hotel at 4 P. M. February 23, 1922. Routine business was transacted.

Paper on X-ray diagnosis and treatment, with lantern slides, was read by Dr. Charles Whelan of Boston, Mass. Collation followed.

A. H. MONTY, M.D., *Secretary.*

HOSPITALS

PROVIDENCE CITY HOSPITAL. CASE REPORT.

Acute pancreatitis is recognized as a complication of mumps, but occurs so infrequently that it is an object of interest when recognized.

A. S., eleven years old, male, admitted March 20, 1922, second day of illness with bilateral swelling of parotid glands. Five days later swelling

gone but still slightly tender. Temperature suddenly jumped to 103.6 with severe abdominal pain and vomiting. Bowels moved three times. Pain general throughout abdomen, but most severe at left of umbilicus. White count 7500, increased to 11,000 in twenty-four hours. Urine showed no sugar but phenylhydrazin test was positive. Stool showed increased amount of fat. Pain lasted 72 hours, and temperature dropped by lysis, becoming normal in 72 hours. Patient discharged one week later apparently well.

HARMON P. B. JORDAN, M.D.

NOTES.

The regular monthly meeting of the Staff Association was held on March 15th, at which time a complete report was made of the patients treated in 1921 by the departments of Dermatology and Syphilis and Neuro-psychiatry in the Out-Patient Department, and of the venereal disease patients treated in the hospital. Case reports were presented by the Department of Neuro-psychiatry.

ETHER AND LAVENDER

Paradoxical as it may seem, if we are to believe the public print, divorces in Rhode Island exceed in numbers, the marriages.

A recently returned traveller tells us that one can live in Albany upon half the cost of living in Providence—it costs only \$10.00 to spit on the sidewalk.

That liberal use of cosmetics is held in great esteem by the female of the species along Broadway, New York.

That "Youth is Served" more fearlessly and more bountifully in Windsor, Ontario, than in any city in the United States.

That he saw a bald-headed man from the States in Montreal with the number of his hotel room painted on the top of his head as a precautionary measure, lest the climate and other things affect his memory.

SYNTHETIC FOOD.

Although he is said to have predicted it, Dean Kimball of Cornell University says it is foolish—so report goes.

We might add that it is belated as well; the whole matter was a finished achievement long before the Dean was born. Boarding-house keepers called it Hash.

HEALTH NOTE.

Never permit a careless person to push you in front of a train.

NOTICE.

NATIONAL BOARD OF MEDICAL EXAMINERS.

The dates for the next two examinations of the National Board of Medical Examiners are as follows: Part I. and II., June 19, 20, 21, 22, and 23, 1922. Part I. and II., September 25, 26, 27, 28, and 29, 1922.

Applications for the June examination should be in the Secretary's office not later than May 15th, and for the September examination not later than June 1st. Application blanks and circulars of information may be had by writing to the Secretary, Dr. J. S. Rodman, 1310 Medical Arts Building, Philadelphia, Pa.

J. S. RODMAN, *Secretary.*

1310 Medical Arts Building,
Philadelphia.

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ing symptoms may not be the result of syphilis which may be shown only by a positive Wassermann reaction.

A small amount of treatment rarely has any effect upon the Wassermann reaction but when a patient has had a considerable amount of treatment, the Wassermann reaction will vary from negative to positive on succeeding days. In such a case a negative Wassermann reaction has little significance.

A Wassermann reaction may be consistently negative in the presence of syphilis. This is particularly true in syphilis of the central nervous system, where the blood Wassermann reaction may be negative while the Wassermann reaction in the cerebrospinal fluid is positive.

A negative blood Wassermann reaction should never be considered as strong evidence against the presence of syphilis of the central nervous system. Where it is suspected, a lumbar puncture should be performed.

In cases of central nervous system syphilis receiving treatment the reactions in the blood and cerebrospinal fluid do not run parallel. In some cases the Wassermann reaction in the blood becomes negative while the reaction in the cerebrospinal fluid remains positive. In other cases the reverse is true. The value of the provocative Wassermann reaction is questionable. It is probable that the same result could be obtained by several repetitions of the test.